Health Care & Dependent Day Care
Reimbursement Accounts
Enrollment

EMPLOYEE INFORMATION			
BNL LIFE #	**BNL BLDG #**	**PAYROLL FREQUENCY: (check one)** ____ MONTHLY ____ WEEKLY	
SOCIAL SECURITY NUMBER	**COMPANY NAME** BROOKHAVEN SCIENCE ASSOCIATES	**ACCOUNT NUMBER** 3210488	
LAST NAME	**FIRST NAME**	**M.I.**	
STREET ADDRESS			
CITY	**STATE**	**ZIP CODE**	

PRE-TAX REIMBURSEMENT ACCOUNTS	
HEALTH CARE REIMBURSEMENT ACCOUNT	**ANNUAL AMOUNT ELECTED:** **$**_____ **NOT a pay period amount**
DEPENDENT DAY CARE REIMBURSEMENT ACCOUNT	**ANNUAL AMOUNT ELECTED:** **$**_____ **NOT a pay period amount**

ANNUAL AMOUNT ELECTED will be divided by the number of pay periods in the Plan Year.

AUTHORIZATION

I hereby authorize my employer to reduce my earnings by the amount(s) stated above for deposit into my Health and/or Dependent Day Care Reimbursement Account and to make this money available to me for the reimbursement of Health and/or Dependent Day Care out-of-pocket expenses as appropriate.

I UNDERSTAND THAT I WILL FORFEIT ANY UNUSED BALANCE IN MY ACCOUNT AT THE END OF THE PLAN YEAR. I ALSO UNDERSTAND THAT I CANNOT CHANGE MY PLAN PARTICIPATION UNLESS I HAVE A CHANGE IN FAMILY STATUS, AS DEFINED BY THE INTERNAL REVENUE CODE SECTION 125.

SIGNATURE	**DATE**

FOR EMPLOYER USE ONLY		
EFFECTIVE DATE (REQUIRED)	**DIVISION NAME** Not Applicable	**DIVISION NUMBER** Not Applicable